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PHILADELPHIA MEDICAL TIMES.

PHILADELPHIA, OCTOBER 13, 1877.

ORIGINAL COMMUNICATIONS.

THE LOCALIZATION OF DISEASED ACTION IN THE ŒSOPHAGUS.

BY HARRISON ALLEN, M.D.,

Professor of Comparative Anatomy in the University of Pennsylvania; Surgeon to the Philadelphia and St. Joseph's Hospitals.

THE anatomical relations of the œsophagus are more varied than those of any portion of the alimentary canal of similar length. Usually ten inches long, one to one and a half inches of this distance lie within the neck, seven inches within the thorax, and one and a half to two inches below the diaphragm. In a state of rest it is slightly flattened as well as contracted, and its mucous membrane is thrown into longitudinal folds, so that its transverse section exhibits a stellated oval. It is slightly narrowed in passing through the diaphragm, and at the beginning of the thoracic portion. Sappey compares the canal to two elongated cones whose apices join at the last-mentioned constriction.

The œsophagus describes three curves: one antero-posterior, which answers to the curvature of the vertebral column, and two lateral. The first lateral curve lies a little to the left of the median line, and terminates just below the origin of the left bronchus. The second lateral curve extends from the last-mentioned point to the diaphragm. These curves might with propriety be named the *tracheal* and the *aortic* curves, since the first lies behind the trachea, and the second to the left of the descending aorta. The relations of the *tracheal* portion of the œsophagus are as follows. The canal lies behind the trachea, with a slight inclination to the left. The pleura is in contact with it on either side. The left subclavian artery lies to the left. It is crossed by the left bronchus, and lies behind the pericardium where that membrane covers the left auricle. The *aortic* portion of the œsophagus at first lies a little to the right of the aorta, but soon crosses in front and to the left of that vessel. To the right and behind lies the azygos vein. Parallel with it pass the pneumogastric nerves, the left going in front and the right behind. The thoracic duct ascends from right to left posteriorly, while still further in the same direction are the right intercostal arteries and the vertebral column. Several lymphatic glands lie on either side of the canal as well as behind it.

Instances are on record of hemorrhages into the œsophagus from the superior vena cava, ascending portion of the aorta, the innominate and right subclavian arteries. The heart has also been wounded by a penetrating foreign body lodged in the œsophagus. These structures might be added to the normal relations under the name of *indirect* or *possible clinical* relations.

If the œsophagus possessed much elastic tissue, causing it to maintain the tubular form, the points most likely to be obstructed in disease or from foreign bodies would be those answering to its narrowest parts, namely, at the beginning of the thoracic segment and the cardiac extremity. Writers have generally assigned the upper and lower portions of the canal as the most frequent sites for the lodgment of foreign bodies and the occurrence of disease. The œsophagus, however, is not tubular in form; its walls when at rest are in contact, and indifferently resist the tendency to stricture or occlusion of the canal under moderate degrees of extrinsic pressure.

The study of the literature of obstruction arising from whatever cause has led me to believe that the œsophagus is more often obstructed at the cricoid cartilage, and at the region where the left bronchus crosses the œsophagus, than at any other place. The first of these localities, it is well known, is frequently the point of lodgment of a foreign body or the seat of carcinoma. The fact that the tracheal curve or the point crossed by the left bronchus is a locality of great pathological interest has been in great measure overlooked. Systematic writers omit any mention of the latter structure as a factor in œsophageal troubles. Thus, Bryant, in his "Practice of Surgery," says that "foreign bodies in the œsophagus are mostly arrested at its origin behind the cricoid cartilage, or at its lower end, just above the diaphragm, the two narrowest portions of the tube, and anything that can be swallowed may be so impacted." Erichsen states that "if a foreign body go beyond the cricoid cartilage it usually becomes arrested near the termination of the œsophagus."

From among ten cases of foreign bodies, which I have collected, three were situated behind the cricoid, four just above the left bronchus, *two* near the cardiac end, and one between the cricoid and left bronchus. I will briefly relate these cases, omitting mention of the cricoid variety.

Case I.—Male, aged 30, in taking a drink of water swallowed an artificial front tooth, with gold plate, which measured one and a quarter inches in length and five-eighths of an inch in height. *A probang was passed eleven inches* before touching it. It was removed by silver wire loops secured to the end of the probang. (John Dearden, *Lancet*, 1869, Oct. 16, p. 540.)

Case II.—Male, aged 21. Swallowed a half-crown piece. At the end of a month hemorrhage occurred from the mouth. Sudden death. Stomach distended with coagulated blood, and intestine, as far as descending colon, contained blood, more or less changed. *An ulceration was found after death at the commencement of the thoracic portion of the aorta.*

Case III.—Male, adult. An impacted fish-bone caused death on the tenth day. An ulcer was found on the right side of the œsophagus, perforating the walls *on the level of the fourth dorsal vertebra* and communicating with the aorta. A similar ulceration had excited thickening around and obstruction of the right azygos vein. (Ramskill, *Lancet*, May 13, 1871.)

Case IV.—A child, aged 5 years, swallowed a halfpenny. The coin was pushed violently downwards into the stomach. Death from enteritis. The coin was not found at the autopsy. *The lower third of œsophagus inflamed.* (Jas. Nicholls, St. George's Hosp. Rep., iv., 1869, 219.)

In Case I. the probang must have reached a point just above the left bronchus. An examination made upon a dead body lying upon a table has shown me that the left bronchus is reached by a probang at the distance of ten and a half inches from the teeth. It is in every way probable that in the living subject, in the erect position, a half-inch might be naturally added to this measurement; to say nothing of the individual variations in length of the parts traversed by the probang. In Case II. the term "commencement of the thoracic portion of the aorta," when paraphrased (as I have ventured to do) as follows, "at a point opposite the third dorsal vertebra," will bring the point of obstruction just above the left bronchus,—the latter structure answering at its origin to the fourth dorsal vertebra. The impaction from a body the size of a half-crown piece would be evident as it approached the bronchus, rather than be detected lying directly behind it. In like manner, in Case III., the phrase "on the level of the fourth dorsal vertebra" brings the point of obstruction to the region of the left bronchus. In Case IV. the coin had most probably been lodged at the bronchus, and the track of inflammation at the lower third of the œsophagus answers to the extent of bruising incurred in the violent passage of the coin and the probang.

The two cases of cardiac obstruction are as follows:

Case I.—Male, 56 years old, in whom a piece of bone had *perforated the right side of the œsophagus a half-inch above the diaphragm*, and wounded the superior vena cava. Death at end of sixth day. Stomach and right pleural cavity filled with coagula. (E. Coëster, *Berl. Klin. Wochenschrift*, Oct. 24, 1870.)

Case II.—Adult male, in whom a fish-bone had *perforated the cardiac end of the œsophagus*, perforating the stomach and diaphragm, and penetrating the posterior wall of the heart, making a jagged wound immediately in the middle of the ventricular septum, and opening the right coronary artery and vein. (*Lancet*, 1860, ii. p. 186.)

It will be at once seen that in both these instances the lesion was occasioned by the sharp, needle-like bone. It is by no means probable that a coin-like, much less a globose, substance would have been so arrested. A striking contrast exists between that portion of the œsophagus above and that below the left bronchus. The upper portion is relatively firmly held between the respiratory passages and the vertebral column, and is subject to no variable deviation from its normal line. But that portion below the bronchus must be relaxed in the marked ascent of the diaphragm accompanying gastric repletion,—a feature somewhat roughly imitated in the subject when the sternum is removed and the diaphragm sags slightly upward. In this position the lower portion of the œsophagus is free from any pressure whatever, and to any other foreign body, save that of the character described in the cases, is not liable to present resistance.

The remaining instance of foreign bodies involves the ascending aorta.

Case I.—Male, 22, after illness of six days, occasioned by the swallowing of a bone, died suddenly from hemorrhage. *The offending*

body had perforated the anterior wall of the œsophagus and the ascending portion of the aorta one and a quarter inches below the origin of the innominate artery. This point, in the language of the recorder, answered to the centre of the middle third of the œsophagus. (Farquharson, Trans. Path. Soc. Lond., 1868, 219.)

In this case it is likely that the obstruction was primarily occasioned by the left bronchus, since the middle third of the œsophagus would nearly correspond to it.*

Nine cases have been collected of cricoid disease, as follows:

Case I.—Male, aged 50. Constriction *below base of cricoid.* From this to the bronchus the œsophagus was dilated. (N. Ward, Trans. Path. Soc. Lond., i. p. 247.)

Case II.—Female, aged 53. Œsophagus *adherent to vertebral column one and a half inches opposite and below the cricoid cartilage.* The œsophagus much thickened and contracted. The constriction extending downwards two inches. A cancerous tumor lay between the œsophagus and trachea opposite the stricture. (E. Andrews, *Ibid.*, xii. p. 100.)

Case III.—Male, 44. *Upper three inches of œsophagus involved* in cancerous tumor ulcerating into left subclavian artery. (Dickinson, *Ibid.*, xii. p. 108.)

Case IV.—Female, 40. Tight stricture at "*upper part of œsophagus*" *opening into trachea.* (C. Heath, *Ibid.*, x. p. 130.)

Case V.—Female, 24. Trachea and *œsophagus excessively diseased nearly as far as bifurcation of trachea.* An oval ulceration existed between the trachea and œsophagus. (Wilkes, *Ibid.*, vi. p. 179.)

Case VI.—Stricture, *four inches below the cricoid cartilage, extending to the bifurcation* of the trachea. (Knight, *Bost. Med. and Surg. Journal*, N. S., vol. vi. p. 348.)

Case VII.—Female, aged 53. *Œsophagus constricted, adherent to vertebræ below the cricoid cartilage.* Carcinomatous tumor in trachea, growing from posterior wall. Disease cancerous. (Gibbs, Diseases of Throat, 2d ed., p. 392.)

Case VIII.—Male, aged 65. *Constriction two inches from upper extremity; an ulcer one inch long extending all round the tube.* On the right side the ulcer communicated with the cavity between the œsophagus and innominate artery. The right subclavian artery, one and a half inches from origin, showed a circumscribed opening into the above-mentioned cavity. Disease cancerous. (Balding, Trans. Path. Soc. Lond., ix. p. 194.)

* The space between the cricoid region and the left bronchus embraces the beginning of the thoracic portion and is the locality of greatest normal constriction. Yet I have secured but one example of lodgment of a foreign body therein. The diminished calibre of the canal at this point is caused by increased development of muscular fibre, and would not of necessity interfere with distention.

Case IX.—Female, aged 35. Cancerous stricture at *cricoid, extending upward to behind thyroid cartilage.* (Holmes, *Lancet*, 1876, ii. p. 824.)

The following twelve cases of obstruction were located at the point where the left bronchus crosses the œsophagus:

Case I.—Female, adult. Cancerous ulcer situated *opposite the bifurcation of trachea.* (Wilks, Trans. Path. Soc. Lond., xii. p. 101.)

Case II.—Female, adult. *Œsophagus impervious towards lower third.* Just above beginning of constriction, free opening into bronchus. (Nunnelly, Trans. Path. Soc. Lond., xiii. p. 74.)

Case III.—Male, 51. Œsophagus three inches from upper extremity involved by epithelial cancer, communicating *with trachea just above bifurcation.* Hemorrhage from first intercostal of right side. (Sydney Jones, *Ibid.*, iv. p. 202.)

Case IV.—Male, 45. *Two inches of œsophagus upward from bifurcation of bronchi* involved. Communication with trachea just above bifurcation. (Budd, *Ibid.*, x. 145.)

Case V.—Male, 50. Stricture *on level of bifurcation* extending down two inches. (Shillitoe, *Ibid.*, xiii. p. 72.)

Case VI.—Boy, 10 years. Œsophagus *dilated opposite bifurcation, where longitudinal ulcer one and a half inches long* communicated with an enlarged, suppurating bronchial gland filling up the interval between the bronchi. (O. Ward, *Ibid.*, ii. p. 208.)

Case VII.—Stricture about *the middle of œsophagus* circumscribed, without involvement of any of the neighboring parts. Associated with cancerous polypus near cricoid. (Cooper Forster, *Lancet*, 1863, ii. p. 247.)

Case VIII.—Disease situated in œsophagus *at "root of the lung."* (Bennett's Practice of Medicine, p. 424.)

Case IX.—Male, 44. *Cancerous stricture opposite bifurcation* of trachea, into which it perforated. (Partridge, *Med. Times and Gaz.*, 1866, p. 338.)

Case X.—Male, 61. Non-malignant ulceration five *inches from upper end of œsophagus, just* beneath the arch of the aorta, communicating with right bronchus. (Partridge, Trans. Path. Soc. Lond., 1857, p. 191.)

Case XI.—Carcinomatous *stricture at middle third of œsophagus.* (Richardson, *Lancet*, 1873, ii. p. 596.)

Case XII.—Male, 54. Carcinomatous *stricture opposite third or fourth dorsal vertebra,* determined by œsophageal auscultation. (Morell Mackenzie, *Lancet*, 1874, i. p. 754.)

It is impossible to estimate the influence exerted by the thoracic narrowing of the œsophagus upon the cases just selected. It is well, however, to bear in mind the relationship.

The following cases, while not in all

instances directly associated with the left bronchus, were at least limited by this structure above, and it is probable, since from the post-mortem appearances the lesions were of long standing, that the first deposition was at the region of the bronchus, the lower portion of the gullet being involved subsequently. This is, I think, a rational supposition, conceding the tendency of cancerous and other growths to extend in the direction of least resistance.

Case I.—Female, aged 37. Cancerous disease at lower part of *middle third of œsophagus, three inches from cardiac end*, opening into second right intercostal artery. (Bristowe, Trans. Path. Soc. Lond., 1857, viii. p. 211.)

Case II.—Female, 25. *Œsophagus from bifurcation to one inch above diaphragm* the seat of simple ulceration, with contraction. Ulceration into pericardium where that membrane is reflected from pulmonary vessels to the left auricle. (J. W. Trotter, Trans. Path. Soc. Lond., viii. p. 317.)

Case III.—Œsophagus *impervious towards lower third*, opening into bronchus. (Nunnelly, Trans. Path. Soc. Lond., 1862, xiii. p. 74.) (*Mem.*—This case might be included in preceding group.)

Case IV.—Disease *five inches from the stomach, extending downward* two inches. (Page, *Lancet*, 1863, ii. p. 248.)

Case V.—Œsophagus involved *three inches above cardiac orifice*, opening into right side of the descending portion of aorta. (W. H. Flower, *Med.-Chir. Trans.*, xxxvi. p. 353.)

Case VI.—Disease extended *from bifurcation to within two inches of cardiac end.* (Sedgwick, Trans. Path. Soc. Lond., viii. p. 48.)

Case VII.—Male, 62. Cancerous disease *behind left bronchus, opening into descending aorta* below, and involving the lung of the left side. Stomach and duodenum contained clot. (Wilks, *Med. Times and Gaz.*, 1861, vi. p. 36.)

Case VIII.—Cancerous disease involving œsophagus from *bifurcation of trachea to the stomach.* (Rees, *Lancet*, ii. p. 284.)

Case IX.—Cancerous disease beginning at *bifurcation and opening thence into pericardium.* (G. W. W. Firth, *Lancet*, 1859, p. 284.)

Case X.—Male, 18 years. Small perforating ulcer of œsophagus one-quarter of an inch below bifurcation, penetrating into pericardium. (J. Forsyth Meigs, *Am. Journ. Med. Sci.*, 1875, 69, N. S., 87.)

The following eight cases were limited to the œsophagus at its lower portion, viz., *between the left bronchus and cardiac end.* In five of them the cardiac orifice was directly involved.

Case I.—Disease in the form of epithelial cancer *involved cardiac orifice.* (Bennett's Practice, p. 340.)

Case II.—Male, 56. Scirrhous *tumor at cardiac orifice extending up three inches.* (Leared, Trans. Path. Soc. Lond., vii. p. 95.)

Case III.—Male, 70. Mass of cancerous disease extended *upward from cardiac orifice three inches.* (Graham, *Ibid.*, vii. p. 128.)

Case IV.—Male, 49. *Rupture of œsophagus one inch long immediately above the diaphragm.* (J. Griffin, *Lancet*, 1869, ii. p. 336.)

Case V.—Male, 64. Cancerous stricture *near cardiac orifice of the stomach* and opposite to the third dorsal vertebra. No ulceration.

Case VI.—Male, 72. *Ulcer two inches long situated above the cardiac orifice.* (Bennett's Practice, p. 424.)

Case VII.—Male, 54. Constriction *one and a half inches above the cardiac orifice.* (Murchison, Trans. Path. Soc. Lond., xv. p. 183.

Case VIII.—Patient 80 years of age. Ulcer about *one inch above diaphragm*, measuring three inches in vertical diameter. (*Mem.*—This will bring it to about lower border of left bronchus.) (C. Heath, Trans. Path. Soc. Lond., ix. p. 211.)

In addition to the influence, fixed and probable, which the left bronchus exerts in locating œsophageal disease, a number of incidental lesions are recognized which appear to be limited by this important structure. An analysis of the cases already quoted will have suggested this truth. To illustrate it further, I give several examples under this distinct heading.

Limitation of morbid action and lesion by the left bronchus, viz.:

Case I.—Male, 47. A *stricture opposite the bifurcation of the trachea*, associated with engorgements of the lymphatic glands in the same neighborhood, caused dilatation of the œsophagus both above and *below* the seat of disease. The stomach was enormously distended, reaching below the umbilicus. (Lewis, *Med. Times and Gaz.*, 1861, p. 332.)

Case II.—A stricture *adherent to the bronchial lymphatic glands* caused dilatation from two inches below rima glottidis to beginning of lower third of œsophagus. (Barker, Trans. Path. Soc. Lond., x. p. 141.)

Case III.—An aneurism of the aorta *below the origin of the great vessels* (*Mem.*, between the fourth and fifth dorsal vertebræ) *ulcerated into walls of œsophagus*, causing a hemorrhage. The blood dissected between the muscular layers of the œsophagus to the cardiac end of the tube, and escaped by a rent though the peritoneum into the abdominal cavity. (T. P. Pick, Trans. Path. Soc. Lond., 1867, p. 477.)

Case IV.—An abdominal *aneurism bursting* just above *the cœliac axis* caused the blood therefrom to pass up behind the œsophagus. The tube was *compressed for three inches above the cardiac* end. (Bristowe, Trans. Path. Soc. Lond., x. p. 88.)

Case V.—Male, 19; juggler. In swallowing a *sword, it penetrated the pericardium.* (*Mem.*—It is in every way likely that a temporary resistance encountered at the left bronchus caused the sword to pass by this point violently, with a deflection of its point anteriorly.) (Parks, Trans. Path. Soc. Lond., vol. ii. p. 40.)

Case VI.—Male, 35. Fissure through mucous and muscular coats immediately below the cardiac orifice of the stomach, and extending upward one and a half inches. An adventitious cavity containing gastric ingesta formed between the outer muscular coat and the fibrous investment, which reached upward *to the root of the left lung.* This collection had in turn communicated by a small orifice with the left pleural sac. (J. J. Charles, *Dublin Quart. Journ.*, vol. l., 1870, p. 319.)

To these cases may be added the congenital union of œsophagus and trachea, which is usually seen at a point just above the bifurcation.

All other sources of extrinsic pressure, such as cancer of the thyroid body, tumors in the posterior mediastinum, pressure from aortic aneurism, or pressure from an enlarged cervical lymphatic, are of course to be excluded; for, as important as these sources of complication are in practice, they have no bearing upon the phase of the discussion now under consideration.

Thus, out of fifty-six cases of intrinsic œsophageal disease, omitting the six cases of limitation of morbid action and lesion, ten were induced by foreign bodies, and forty by disease. The dictum concerning the points of obstruction quoted at the head of the paper will not be, I think, sustained by any impartial reader who has accompanied me thus far. Out of the nine foreign bodies, while three were lodged at the cricoid region, three were just above the left bronchus, and only two near the cardiac end: in both of these, the foreign bodies being sharp bones, the cases presented peculiar features.

In examples of diseased condition, ten were situated at the cricoid, twelve at or near the left bronchus, ten in which the disease while below the left bronchus was very near or involved the latter, and eight only in which the disease was at or near the cardiac end.

It is in every way likely that if all the cases recorded in medical literature were examined, the proportionate number of instances of invasion of the cricoid region would be increased. But the relations existing between the location of morbid action in the neighborhood of the left bronchus and cardiac end would remain about the same. This supposition is based upon the fact that many of the cricoid cases are classified with pharyngeal disease, while no such source of error is likely to occur in the examination of the remaining portion of the canal.

Mr. Crisp (*Lancet*, 1873, vol. ii. p. 628) reasserts, after an analysis of twenty-one cases recorded in Trans. Path. Soc. Lond., that the constriction was found eleven times in the lower portion, nine in the upper, and but once in the middle.

It is very evident that this writer has assumed a different standard of measurement from mine in arriving at such a widely-different conclusion. While it is convenient to speak of the œsophagus as being thus divided into thirds, it is, I think, more accurate to describe it by the standard of its most important anatomical relations; and I believe that the cricoid cartilage, and the point where the tube is crossed by the left bronchus, are the two most valuable of these.

Any one can convince himself that writers have been at a loss for fixed points of comparison in describing their cases. Some refer to a strictured point as so many inches below the epiglottis, or as so many inches below the origin of the left subclavian or the root of the lung, or as so many inches above the cardiac end, etc. In not a few cases I have been compelled to translate these terms by measurements from vertebræ in the immediate neighborhood of the assumed points, or by others instituted from above downwards in the axis of the canal. A few of these it may be well to give in this connection:

Length of the œsophagus, ten to eleven inches.

The cricoid cartilage is at the upper orifice of the œsophagus.

The left bronchus crosses the œsophagus obliquely from the fourth to the fifth dorsal vertebra.

The distance from the cricoid cartilage to the bifurcation is from four and a half to five inches.

The distance occupied by the left bronchus in crossing, about an inch.

The distance from the left bronchus to the cardiac orifice, four to five inches.

End of the aortic arch, about the third dorsal vertebra.

From the teeth to the cardiac end of the stomach, fifteen to sixteen inches.

From the teeth to the left bronchus, from ten to ten and a half inches.

From the teeth to the upper edge of the arch of the aorta, nine inches. To the lower edge of the same, ten to ten and a half inches.

The following conclusions are drawn from the foregoing statements:

1. Foreign bodies are liable to be retained at the beginning of the œsophagus behind the cricoid cartilage.

2. Passing this point, they do not, as a rule, reach the cardiac end, or "lower part," but are apt to be lodged *just above* the left bronchus as it crosses the œsophagus.

3. The cricoid region is exceedingly liable to invasion, and if the disease extends thence downward it is often limited by the left bronchus.

4. It is probable that diseased action may occasionally originate at the point of greatest narrowing of the thoracic portion, viz., just below the superior thoracic aperture.

5. The region of the left bronchus is very frequently attacked, the disease commencing either *behind* or *just below* it, and extending thence downward.

6. The cardiac end of the œsophagus is less frequently attacked than either the cricoid or bronchial portions.

7. Resistance at or near the left bronchus can be detected by a probang meeting resistance at eleven inches from the teeth.

8. The dangers attending the forcible use of the probang below the region of the cricoid become more manifest when the anatomical relations of the left bronchus are borne in mind.

A CASE OF STRYCHNIA-POISONING, WITH RECOVERY.

BY H. G. LANDIS, M.D.,
Professor of Obstetrics in Starling Medical College.

MR. Z., æt. 29, suffered during the spring and summer of 1876 from great despondency concerning business affairs. Although a temperate and religious man, he began to tamper with drugs, for which his occupation (pharmacy) afforded fatal facility. His first essay was with ten grains of morphine. Fortunately, violent vomiting set in, and he escaped after a few days' illness. Not encouraged by this trial, he abandoned the idea of suicide for a time, but shortly before the occasion of the present description made another effort to depart from life by the same road, which was also unsuccessful. It is worthy of note in this connection that he had the somewhat common insusceptibility to the narcotic effect of opium, being always kept awake by a moderate dose. Finally, in December, having further impaired his stomach and reason by constant nibbling (so to speak) at narcotics and stimulants, he took several grains of strychnia just before supper. He did not himself know the exact amount, but it was over two grains. At supper he moodily drank a cup of coffee, but ate nothing, and in a few minutes rose and went into an adjoining room to lie down on a lounge. Happening, providentially, to enter the room within five minutes after, I found him in a general convulsion, with some opisthotonos. Sulphuric ether being at hand, I at once began to administer it, the second convulsion coming on in one minute. During the interval he groaned as though in great pain, but was almost completely relaxed. The ether was pushed, and a drachm of bromide of potassium administered with difficulty.

The jaw was partially set, and the handling caused an abortive convulsion. There was at first some reason to suppose that the attack was hysterical; but the regularity and profusion of the symptoms all pointing to strychnine, and the patient, who was conscious throughout, but unable to speak plainly without bringing on spasm of the jaw-muscles, finally admitting that he had taken "something," an emetic of ipecac, mustard, and warm water was given. Swallowing was difficult, but about a half-pint of the emetic was taken. In thirty-five minutes he vomited, at first slightly, then profusely. The ejecta were not tested for strychnia, as it seemed superfluous. At the time of giving the emetic, an enema was administered containing potassæ bromidi ʒiss, chloral-hydrat. gr. lxxx. In about an hour another, with ʒi of the bromide and ʒiss of the chloral, was given, and in another hour ʒii of the bromide alone were injected. The first convulsion occurred about 5.30 P.M., the last one at 10 P.M.,—soon after which he began to doze, though he slept very little during the night, in spite of the large doses of bromide which were continued at intervals per orem.

In this case there were six convulsions in all, but only the first two were severe. After these, the ether controlled them perfectly. He could himself foretell their onset for a few moments, by the intense muscular pain to which the incipient spasm gave rise. Hence a few deep inspirations of ether could be taken in time either to prevent or to greatly modify their action. As they declined in severity the interference with speech was less. After the third he was able to speak quite well,

—in fact, became loquacious from the ether. The condition in the first and second convulsions, therefore, in which the jaw was as rigidly set as any other part of the body, was only an apparent exception to the rule that in strychnia-poisoning the jaw is last and least affected, and was due, presumably, to the overwhelming effects of a very large dose. These convulsions were very general, not a muscle escaping, and the attack being so sudden that it was impossible to determine any point of beginning. In the others, pain in the back and limbs was the invariable precursor. Certainly nothing could be more happy than the effects of ether in this case; but I am disposed to give it only a secondary place as a curative agent. It relaxed the system sufficiently to allow of the administration of the remedies; but the bromide as recommended by Prof. H. C. Wood is evidently the true physiological antidote. Recovery in this case was prompt. The patient was unable to void urine for a day or two, necessitating the use of the catheter, and considerable gastric irritability remained for some weeks. With rest and mental relaxation, he improved rapidly, and has remained well up to date, with no return of suicidal mania.

Columbus, Ohio, Sept. 1877.

ERGOT IN HEMORRHOIDS.

BY EDWARD S. LANSING, M.D.

IT is conceded by the curious and most careful investigators and experimenters, and confirmed by the clinical observations of many practising physicians, that ergot produces a very decided effect upon the unstriped or involuntary muscular fibre, exciting it to contraction.

The uterus in the gravid state is the most familiar example in which its power is susceptible of very satisfactory observation.

In atonic hemorrhages, hæmoptysis, hæmaturia, its efficacy is acknowledged. In chronic congestion of the spinal cord and its coverings, its power to cure is vaunted by no less authority than Dr. Brown-Séquard. In the last-mentioned diseases the capillaries are involved.

Considering the pathological condition denominated hemorrhoids to consist in an enlarged condition of the veins (an increased length and diameter as a result of hæmostatic pressure at some time) which continues after the inducing cause or causes are removed, simply on account of the relaxed and feeble condition of their coats, and conceding the power of ergot upon that greatest aggregation of unstriped muscular fibres in the human system,—the uterus,—also its power upon the capillaries, where the presence of the unstriped fibre has with difficulty been determined, as in hæmaturia and chronic congestion of the spinal cord, it suggested itself that ergot ought to relieve, and with so many favorable factors one could reasonably expect it would cure, many cases of hemorrhoids.

Having an intractable case on hand of twelve years' standing, I tested it.

I used ergotin in suppositories, four grains each, night and morning at first, subsequently at night only.

The first effect of the ergotin was to produce pain for half an hour or more, but after the use of three or four no unpleasant effect attended their use.

The hemorrhage ceased, the congested condition of the parts yielded, the hyperæsthesia was replaced by normal sensation, the hard, cordy condition of the veins passed away, and the slight tumefaction remaining suggested interstitial fibrinous exudation or cellular hyperplasia.

Having treated five cases with the ergot, in four of which the result was more satisfactory than I anticipated, the fifth is still under active treatment.

Having never seen the treatment suggested, and the result in my cases being so happy, I offer it that others may test it, and possibly much relief accrue to a numerous class of great sufferers.

Burlington, N. J.

NOTES OF HOSPITAL PRACTICE.

NOTES OF MEDICAL TREATMENT AT THE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

Prepared for the *Medical Times*.

GRAVES' DISEASE.

IN the treatment of this disease the greatest care must be given to the removal of the causes, and in securing rest, good food, change of scene, and entire release from care. The various functions must be attended to, and any local disorder in females removed by suitable treatment.

Digitalis is the most valuable remedy for controlling the functional disturbance of the heart. It may be given freely in doses of from ten to fifteen drops, three or four times a day, and continued for long periods. When anæmia exists, large doses of iron must be administered. Most excellent results have been obtained from the injection of diluted solutions of ergot into the enlarged thyroid gland. The needle may be introduced to the depth of half an inch or an inch, and from six to ten minims of a solution containing ninety-six grains of ergotin to the fluidounce of distilled water injected. Bromide of potassium is valuable in assisting the iron and ergot in controlling the irregular action of the heart and arteries.

ULCER OF THE STOMACH.

Nitrate of silver, in the form of pills, should be given in full doses half an hour before meals. If there be pain, opium, hydrocyanic acid, and chloroform may be administered. An exclusive milk diet is the best. All solid food must be avoided. At the time of hemorrhage, absolute rest must be insisted upon; pieces of cracked ice should be swallowed. Monsel's solution, tannic or gallic acid, should be given internally; morphia may be administered by the mouth, and ergotin hypodermically, and all food given by enemata for the time.

LUMBAGO.

Manipulation must be applied to the lumbar region of the spine, so as to restore mobility. To subdue the painful condition of the muscle, injections of one-eightieth of a grain of atropia and one-eighth of a grain of morphia, well diluted, should be made well into the body of the muscle. Great care must always be had in the administration of morphia and atropia to nursing women, as belladonna is the most powerful anti-galactagogue known, and too large doses of morphia not rarely affect the child through its milk. The local application of blisters, iodine, and croton oil, together with the internal administration of iodide of potassium, often does good.

INCIPIENT PHTHISIS.

Among the most important hygienic measures are good food, healthful out-door exercise which will expand the chest, and an equable climate, such as may be found in the south of California, New Mexico, or the southern and western slopes of Colorado. Sea-voyages, such as a cruise to some tropical ocean, and not sailing about in an inclement climate, as many consider the term to mean, are most plainly beneficial. If these ways of regaining lost health be out of the question, and the patient be compelled to stay at home, inhalation of compressed air may be tried with success. Counter-irritation may be applied over the seat of disease, and cod-liver oil, the syrup of the iodide of iron, arsenic, and the hypophosphites of lime, soda, and iron, administered internally.

IDIOPATHIC EPILEPSY.

As a general rule of treatment in epilepsy, all the existing causes of an attack, such as mental excitement, over-eating, indigestible articles of diet, should be avoided. As concerns medicinal agents, the bromides are of especial value as controlling remedies. The initial dose should be twenty to sixty grains, thrice daily, the dose to be increased in size until either the paroxysms stop or *bromism* is produced.

TETANUS.

Systematic feeding of patients with liquid and strengthening food at short intervals has been employed with very good results. The food must be given at intervals of every two or three hours, and should consist mainly of milk, with a small quantity of alcohol. In severe cases all solid food must be avoided. As for medicines, the patient must be brought well under the influence of the bromide of potassium by an initial dose of two drachms to half an ounce, to be followed by half a drachm to a drachm every three or four hours. To force sleep at night, give at bedtime thirty grains of chloral with some opium. Chloral also may be used, when necessary, in daytime. Nitrite of amyl and chloroform should not be used steadily, but may be employed from time to time to stop violent spasms. If *bromism* be produced, chloral and opium should be relied on, or cannabis indica may be substituted for the bromides. Where there is much cerebral congestion, a blister is put on the nape of the neck.

TUBERCULAR LARYNGITIS.

The local application of pure nitric acid or of strong solutions of nitrate of silver is of great value. For the œdema, astringent solutions, such as the sulphate of zinc, copper, or alum, may be recom-

mended. Gargles and inhalations can be used for the cough. The following formula will be found of value:

℞ Tinct. benzoini comp., f℥ij;
Glycerinæ, f℥ss;
Aquæ, q. s. ad f℥iv. M.
Sig.—To be used as a gargle.

Inhalations of steam, vapor of hops, or conium, are sometimes successful as palliatives. Counter-irritation may be applied externally to the larynx in the shape of small blisters. To relieve the sense of fulness, lozenges of krameria, hæmatoxylon, or tannic acid are prescribed. In desperate cases tracheotomy must be performed [see *Gleanings*, p. 23], and a metal tube worn, thus putting the much-irritated larynx at rest.

CHRONIC INFLAMMATION OF BOWELS.

Individual symptoms must be borne in mind. Alcohol, green vegetables, fruits, and meats must be refrained from. Buttermilk, beef-juice, milk with lime-water, and light farinaceous foods are the safest articles of diet. The clothing should be amply sufficient, and all excessive exposure avoided. Among medicines the proper mode of treatment is that by nitrate of silver in pill form, one-third of a grain from one to two hours after meals. The treatment must be long persevered in to effect a permanent cure.

CATARRHAL JAUNDICE.

In the treatment of this complaint, early efforts must be directed to the allaying of the irritation of the mucous membrane of the stomach and duodenum. Do not begin by acting on the liver with cholagogues and mineral acids. All exposure must be avoided. A tumblerful of some one of the alkaline mineral waters should be taken twice daily, and nitrate of silver, with small doses of the extract of belladonna, given in pill form. Belladonna prevents spasmodic irritation of the ducts. Where there is much local irritation, blisters may be applied over the gall-duct and gall-bladder. After irritation has subsided, mercurials or mineral acids come into play.

HEART-CLOT IN DIPHTHERIA.

The most important part of the treatment is prophylactic: there is no remedy known which will avert this dreadful accident, but there is little doubt that by judiciously sustaining the tone of cardiac action, and by carefully guarding against all muscular exertion, especially in the way of sitting up or rising to the feet, a good deal may be done to lessen the danger of its occurrence. Should it become evident that the formation of heart-clot has taken place, the only treatment to be recommended is active stimulation of the tone of the heart. The various remedies which have been advised, with the idea that the solution of the clot might be promoted, are useless. Ammonia is valuable, not in this latter way, but simply as a stimulant to respiration and circulation. Alcoholic stimuli and concentrated nourishment must be given as freely as seems called for by the prostration and the depression of circulation. More reliance is to be placed upon digitalis, freely administered, than upon any other remedy. Absolute avoidance of muscular effort must be insisted upon.

SACCHARINE DIABETES.

The diet must be modified by the exclusion of all sugary and starchy elements of food. The most valuable drug is opium, used in large doses for a long time. Ten grains may be given daily without producing the slightest drowsiness. Under this treatment the amount of urine passed daily will greatly diminish, and the proportion of sugar gradually grow less.

CARCINOMA OF THE LIVER AND OMENTUM.

Treatment must generally be limited to the relief of pain and the use of a well-selected diet. In some cases of non-cancerous internal growths, arsenic given in very large doses for long periods of time may do good. Pain must be checked by opiates, and the strength maintained by large doses of iron and the bitter tonics.

CHRONIC ARTICULAR RHEUMATISM.

The most successful mode of treatment has been by manipulation of the anchylosed joints, and counter-irritation applied to the nerve-trunk higher up the leg. The continued current with the positive pole placed over the point of tenderness, and the negative pole higher up the nerve, may also be employed. When the foot is affected, a shoe should be constructed which shall take the strain off the painful joint and throw the weight of the body on the outside of the foot (this for rheumatism of the joints of the foot, of course). Where there is a decided rheumatic diathesis, the persistent use of the following prescription is followed by advantageous effects:

℞ Pulv. guaiaci resin., gr. x;
Potass. iodidi, gr. x;
Tinct. colchici semin., f℥ss;
Aq. cinnamomi,
Syrupi, āā q. s. ad f℥i. M.

Sig.—A dessertspoonful to a tablespoonful thrice daily.

ADENITIS

Is treated by continued injections of dilute ergotin in the substance of the inflamed gland.

CYSTIC TUMOR OF THE LIVER.

The only mode of treatment is by repeated tapping of the cyst or cysts, and the injection of iodine into the cavity. In evacuating hydatid cysts, some have recommended causing adhesions between the cyst and the abdominal walls by escharotics and then making a free opening into the sac and maintaining it until the cavity is altogether obliterated. This method is often followed by fatal results. The safest method is that by the trocar and canula and aspiration. This operation affords but very slight danger of peritonitis.

ACUTE GASTRO-HEPATIC CATARRH.

In these cases, if a malarial nature be suspected, it is well to begin with full doses of quinia. If, however, the gastro-hepatic symptoms are prominent, the quinine treatment should be postponed for twenty-four hours, and from five to ten grains of blue mass given, followed by a saline. Then, when the liver and stomach have been well acted upon, quinia should be given by the rectum, so as to avoid gastric irritation. Four suppositories, of five grains each, should be given at intervals of from two to three hours. The diet should be restricted, and febrifuges and subacids given, and the skin sponged with cold water if the fever be severe.

TYPHOID FEVER.

Beginning with the second week of the disease, when the abdominal symptoms have fully set in, one-quarter of a grain of nitrate of silver, and from one-sixth to one-half of a grain of the watery extract of opium, with one-twelfth of a grain of belladonna, are exhibited in pill form, three times a day, after meals. Very little stimulus is used. Milk and beef-tea are the only articles proper of food allowed. Quinia is given with other tonics. Fever is reduced by frequent spongings of the entire body with cool water. When the high fever resists sponging, cool baths are employed.

TRANSLATIONS.

Condition of the Blood and Marrow in Pernicious Anæmia.—Dr. Osler, of McGill University, in a communication to the *Centralblatt f. Med.*, 1877, p. 498, gives the following appearances as observed by him in the above-mentioned disease. The blood examined before death was thin and watery, and showed no increase of white blood-corpuscles. The red corpuscles were pale, flat, and irregular in form. The microcytes so often observed in this affection were very numerous, often ten to twelve in a single field. Nucleated red bodies were not found, nor were those large colorless elements, resembling marrow-cells, which Litten describes, seen.

The marrow of all the bones examined—sternum, ribs, vertebræ, fibula, radius—was dark violet red, and, with the exception of that of the fibula, contained no fat. There were found the usual marrow-cells, both the large coarsely granular and the small lymphoid varieties, as well as red blood-corpuscles. There were also nucleated red bodies, resembling in every respect those described by the author in a former number of the *Centralblatt* (1877, p. 258). These were particularly numerous in the sternum, least so in the vertebral medulla: they were considerably larger than ordinary red corpuscles, and of an equally dark color. Most of them had a single nucleus, but occasionally two, three, or even four nuclei were observed. The nucleus lay, as a rule, excentrically, often in fact protruding half-way out of the cell. In these instances they appeared uncolored. x.

The Cause of Sleep.—Dr. Preyer, of Jena (*Journ. des Sci. Méd.*, 1877, p. 374), the reporter upon this subject at the recent International Medical Congress at Geneva, formulates certain conclusions on this subject, which are essentially as follows. Normal sleep is a condition of the organism altogether different from somnolence, coma, asphyxia, or narcosis, with which it is often confounded. The principal difference as to cause consists in the fact that fatigue (of the organs of sense, of the muscles, or of the brain) precedes natural sleep. No psychical phenomenon of any kind can manifest itself if the brain has not a certain quantity of oxygen at its disposal, which is brought to it by the blood. If the ganglionic cells lack oxygen, the cerebral actions are suspended as in sleep.

Since the brain of a sleeping animal receives as much blood and as much oxygen as in the waking condition, it must be admitted that the oxygen of the blood no longer needed for psychical acts is employed otherwise than in the waking condition. Certain substances are formed during labor which exist only in a minimum quantity during the condition of repose. Such are lactic acid and creatine. These accumulate in the organs, and, as they are very oxidizable, they consume the oxygen required by the brain and muscles during action. The commencement of this accumulation marks fatigue; its end, awakening. In fact, lactic acid introduced into the system causes fatigue and sleep, if all excitation is avoided. It must be admitted, however, that lactic acid introduced into the organism occasionally fails to produce the effect indicated. x.

Use of Anæsthetics during Natural Labor.—This question was discussed at the recent International Medical Congress at Geneva (*Journ. des Sci. Méd.*, 1877, p. 368). The reporter, Dr. Piachaud, of Geneva, advises the use of anæsthetics in natural labor in a general way. He prefers chloroform given after Snow's method,—that is, in small amounts at the beginning of each pain, suspending it in the intervals. Complete insensibility is not to be produced,—only sufficient to mitigate the pain. Usually chloroform should be given only during the stage of expulsion. In cases when the patient is very nervous or extremely agitated, it is advisable not to wait for complete dilatation of the os before employing anæsthetics. Experience has shown that while anæsthetics do not suspend the muscular action of the abdominal and uterine muscles, they cause the perineum to relax. Their employment is followed by no evil effects to mother or child. The use of anæsthetics, by diminishing suffering, frequently prevents nervous crises, and, in addition, hastens the rapidity of recovery. Anæsthetics are particularly useful for the purpose of calming the extreme agitation and cerebral excitation frequently produced by labor in very nervous women. Their employment is indicated during natural labor when the progress of the process is retarded or suspended by pain caused by anterior affections or those supervening during labor, and in cases of irregular and partial contractions occasioning suffering without aiding the progress of labor. In natural labor chloroform should never be used without the assent of the patient and family. x.

Acute Myelitis.—C. Lauenstein (*Deutsches Archiv für Klin. Med.*, xix. p. 424) gives the case of a man 45 years of age, who having caught cold was attacked, after a prodromal stage continuing for ten days (pains in the back and stiffness in the limbs), with high fever and sweating, followed by complete paralysis, motor and sensory, of both upper and lower extremities, together with retention of urine. During the first day the reflex movements were obliterated. After the second day they came back,—at first feebly. The limbs, at first numb, were later stiff, so that they retained their position when moved, and displayed fibrillar twitchings of the muscles. Respiratory disturbance was followed by death on the third day. Post-mortem examination showed the cervical medulla softened from the beginning of the third cervical nerve down, and, on section, of an even pale red. The veins of the pia mater were filled; in fact, in the posterior part of the cervical medulla itself they were also injected. The dorsal and lumbar medulla was found macroscopically and microscopically intact. Neither hemorrhages nor nucleated cells were found in the altered cervical medulla; very marked enlargement of the axis-cylinders was, however, observed; the medullary sheath was frequently wanting in the latter. These changes, as well as maceration of the neuroglia fibres and enlargement of the stellar cells, were found principally in the centre of both lateral columns of the cervical medulla, especially towards the periphery. Among the swollen axis-cylinders uncolored spaces of various size were observed. The rest of the medulla was substantially good. The author says that the occurrence of paralysis of reflex movements only during the earlier hours of the disease is interesting, and suggests the similar phenomena observed just after division of the cord in animals. x.

Treatment of Ozæna.—At the recent International Medical Congress at Geneva the reporter upon this question was Dr. Ronge, of Lausanne. His conclusions were as follows:

1. Ozæna, a special fetidity of the air expired by the nose, results from suppuration of the nasal fossæ or their annexes,

which are,—the frontal sinus, the ethmoid cells, the sphenoidal sinus, the maxillary sinus.

2. The point of departure for this suppuration always appears to be an alteration of the bones of the nasal fossæ or their annexes.

3. The degree of fetidity of the nasal breath is determined by the extent of the osseous lesion : the greater this is, the more severe the ozæna.

4. Apart from the osseous lesion, the stagnation of pus in the sinus, from which it can only escape by drops, contributes to the production of ozæna.

5. When the cause of the ozæna is not found in an alteration of the walls of the nasal cavity, the sinus and the cells of the ethmoid must be examined.

6. The local treatment of ozæna is as follows :

(*a*) Cleansing of the nasal fossæ by means of douches and frequently-repeated irrigation. The liquid employed varies according to the indications.

(*b*) Insufflation of astringent, caustic, or disinfecting powders.

(*c*) Cauterization with solid, liquid, or pulverulent chemical caustics. Employment of the galvano-cautery.

(*d*) Scraping the ulcerations, extraction of sequestra, drainage of the sinus. To fulfil this indication it is necessary to detach the nose by the sub-labial process, which permits direct exploration of the nasal fossæ, extirpation of the necrosed parts, and opening the sinus. This procedure leaves no apparent cicatrix and no deformity. X.

Functions of the Spleen.—At the same meeting Dr. Schiff, the well-known physiologist, made a report on *the functions of the spleen*. His conclusions were as follows :

1. Extirpation of the spleen has no lasting influence upon the absolute or relative quantity of the white or red globules of the blood.

2. For a short period after the operation a considerable augmentation of white globules, with or without diminution of red globules, is observed. These alterations do not depend on the absence of the spleen, but only on the operative procedures necessary to the ablation of the organ, and these phenomena remain very much the same if the preparatory manœuvres are not followed by ablation of the spleen.

3. After ablation of the spleen, swellings of the lymphatic glands rarely take place, nor do enlargements of other glands. The so-called supplementary spleens are not found, even when the animals are allowed to live for more than a year and a half after the operation, and even when this has been performed within a few weeks after birth.

4. Swelling of the mesenteric glands, which is occasionally observed in animals deprived of the spleen, appears to be due to a peritonitis, partial, but prolonged, which sometimes follows the operation.

5. The spleen appears to augment in volume from the fourth to the seventh hour of a sufficient stomachal digestion.

6. The spleen during digestion, or rather during the stomachal absorption, prepares the ferment which, entering with the blood the tissue of the pancreas, transforms in this gland a special substance (probably albuminoid) into *pancreatopepsin*, or trypsin,—that is to say, a substance apt to digest albuminoid bodies.

7. After the extirpation of the spleen, the pancreatic juice loses its digestive influence on albuminoid bodies, while preserving its other digestive properties. The duodenal digestion of the albuminoids is no longer distinguished by its energy and rapidity : it is then feeble, as in other portions of the small intestine.

8. After ablation of the spleen, the substance destined to form pancreatopepsin accumulates for the most part in the pancreas, and may perhaps be transformed into pancreatopepsin under the chemical influences which accompany the commencement of putrefaction after death.

9. After the destruction of its nerves the spleen remains flaccid. It no longer enlarges, and it becomes atrophic, as in general do erectile tissues whose vascular nerves are paralyzed.—*Journal des Sci. Méd. de Louvain*, 1877, pp. 365, 375. X.

Asserted Death from Poke-Root.—Dr. W. S. Battles reports (*Ohio Medical Recorder*, August) the case of an old lady who took a pint of decoction made from an ounce and a half of fresh poke-root, and was found dead in her bed next morning. No autopsy was made, and it seems more than doubtful whether death was caused, as asserted, by the drug.

Dr. Hugh Algernon Weddell, famous for his researches upon the cinchona family of plants, died July 22, at Poitiers, France, in the fifty-ninth year of his age.

PHILADELPHIA
MEDICAL TIMES.

PHILADELPHIA, OCTOBER 13, 1877.

EDITORIAL.

MODERN HOMŒOPATHY.

DRS. T. F. Allen and Samuel Swan, both of the city out of which wise men sailed in a tub, are engaged in a duel *à l'outrance* concerning the relative values of the "millionth fluxion potency" and the "thousandth centesimal potency." In the *Hahnemannian Monthly* for September we are informed by Dr. Swan that the "square root of a fluxion potency will represent the highest possible Hahnemannian potency,"—which assertion shows the doctor to be a great and good man. We are dumb with wonder at the intellect which controls the power of these square roots,—a power which can root out all the ills of human flesh. We tremble at the might shut up in even a "fifth centesimal Hahnemannian potency," when "by spectroscopic test the distinguishing bar has disappeared," and the freed spirit of the drug, no longer devitalized as substance, is a nascent force. "The most useful potencies are those so high that all physical and chemical qualities are eliminated." It is with such pure sublimated force that the demons of disease are to be driven out of the human system. Think of Sepia, its blessed spirit of healing so imprisoned in its worse than carnal body that it is powerless—bound in atoms of matter as by the hand of a giant—until the Aladdin lamp of potentization liberates it for its mission of recuperation and joy.

Dr. Swan has pushed forward the discoveries of pure homœopathy until he ranks as a second prophet, approaching even unto him who has gone before, the immortal Hahnemann. He has proven "that morbific products will cure the diseases that produced them, if given in high attenuations and to other persons than those from whom they were procured." Listen, O sons and daughters of suffering; endure not till the morning. Hie away to the spit-cups of Blockley and the cancer-rags of Bellevue! There shall you find healing, and, rising as from the fountains of eternal youth, shall call *him* blessed among men for evermore.

BICARBONATE OF SODIUM IN BURNS.

SOME months since, a paragraph went the rounds of the daily press, asserting strongly the value of the bicarbonate of sodium in burns. Not long after, in one of the University laboratories in this city, an assistant of the editor of this journal burnt the inside of the last phalanx of the thumb severely whilst bending glass tubing. The saturated solution of the bicarbonate of sodium, used in the cardiometer, was at once applied: in five minutes the pain was gone, and with it all soreness, so that the part, although blistered, was freely used and pressed on in bending tubing, screwing up and unscrewing apparatus, etc. In the last number of the *Louisville Medical News*, Dr. Coleman Rogers reports a case of a burn of the second degree, involving two-thirds of the face, both ears, and extending over the whole back of the neck to down between the shoulders, in which the pain was "promptly and permanently" relieved by applications of the soda. Washing-soda is so easily obtained, and the relief we saw was so quick and complete, that we trust the profession will at once try the new asserted remedy.

ADULTERATED LIQUORS.

THE quantity of fancy liquors, from brandy to champagne, drunk by any man may be known to him, but the quality must always remain an "unknown quantity." A peep into the vista is given in a

paper by Mr. Henry G. Debrunner in the October number of the *Journal of Pharmacy*. A sample of a genuine French brandy was carefully examined, and found to contain the violent narcotic poison nitro-benzole in large quantity. For the benefit of those who prefer knowing what they drink, or are desirous of saving a penny, Mr. Debrunner gives a formula for preparing this choice liquor. Take of common alcohol and of water, each, two quarts; mix, and add of nitro-benzole half a fluidounce. Agitate. Picric acid or trinitrophenol having been previously detected in beer, nitro-glycerin will be next in order.

A few weeks ago we called attention to the so-called "Maxwell case," and to the fact that in the discussion which was going on there was an evident endeavor to delude the general public into the belief that the issue was one between the regular profession and the homœopaths.

Subsequent developments have simply confirmed us in our original opinion, that the only point of interest in the case is that the managers of a public institution should have been so negligent as to have permitted an insane or imbecile person who had shown marked suicidal tendencies, to occupy, unguarded, a room in the fourth story of their building. It was not proven that Dr. Mullen had refused to sign the certificate of insanity because the other names upon it were those of homœopaths, but it was shown, on the contrary, that his failure to do so was from lack of opportunity to make a personal examination of the patient, as is required by the laws of the State and of the Board of Guardians. Some interesting facts were brought to light concerning the attention which the patients at this "Home" receive from the managers and the visiting homœopaths, and the ratio which seems to exist between that attention, the pecuniary circumstances of the patient, and the amount of trouble which he gives; but this aspect of the affair is at once complicated and discouraging. The committee of the Board of Guardians very properly sustained its own excellent rule requiring one of the doctors examining cases for admission to the insane asylum to be an officer of the Board, and also exculpated Dr. Mullen from all blame in the matter. We wonder if an investigation into the management of the "Home for Aged Colored Persons" and the conduct of its officers would have as satisfactory a result.

CORRESPONDENCE.

New York, September 28, 1877.

To the Editor of the Phila. Medical Times:

DEAR SIR:—The first of our societies to resume operations after the summer vacation this year has been the Academy of Medicine, which held its first meeting on the 20th of September. On this occasion about two hundred and fifty valuable books, from the library of the late Dr. J. H. Johnson, were presented to the Academy by his family, and among them were some very interesting manuscript volumes, written by Dr. John Bard, the father of Samuel Bard, the founder of what is now the College of Physicians and Surgeons, and the great-grandfather of Dr. Johnson. The paper of the evening was by Dr. Beverly Robinson, on "*The Mechanism and Treatment of the Pulmonary Complications of Acute Cardiac Affections.*" He first spoke of endocarditis, and described the phenomena accompanying it, and the pathological changes resulting in the cardiac valves, which at first contract badly, while later there is rigidity and narrowness of the orifices. In consequence, the respiratory function is more or less interfered with, the amount of interference varying in different cases. He was disposed to think that Flint under-estimated dyspnœa as an element of endocarditis, and agreed rather with Valleix, who found it of frequent occurrence. The pulmonary complication might be dependent merely on congestion, or might amount to extensive inflammation. Again, dyspnœa might sometimes be due to nervous irritation, and was also, no doubt, sometimes caused by the formation of coagula in the right heart. In the latter case the respiration is noisy and labored, and on percussion there is found to be increased vesicular resonance, the pulmonary vesicles being distended to their utmost capacity, and the respiration in consequence almost emphysematous in character. There is marked congestion and often œdema of the pulmonary

tissue. Sometimes, it had been shown, coagula formed in the left heart before the right; but this was unusual. Dr. Robinson next spoke of ulcerative and diphtheritic endocarditis, so apt to result in minute embolisms, and then of pneumonia, which frequently follows endocarditis, but sometimes makes its appearance simultaneously with the latter. Some authors would then regard them both as due to the same morbific cause, such as rheumatism or a puerperal dyscrasia; but he was not willing to subscribe to this opinion. Pneumonia, he acknowledged, however, was more apt to follow endocarditis in adynamic conditions of the system; and there was now a well-recognized form of the disease known as embolic pneumonia.

The author of the paper then went on to mention dyspnœa in pericarditis as a symptom of great importance, and claimed it as pathognomonic of this affection in children when there was nothing present in the lungs to account for the difficulty of breathing. After alluding to the causes of the dyspnœa, he proceeded to show why this symptom varied so much in different individuals. As a rule, patients who are weak and anæmic suffer much less from dyspnœa than those who have been previously in robust health; and, again, if the pericarditis is very severe in its onset and runs its course very rapidly, the dyspnœa is apt to be much greater than if the disease is not of so active a character. Then sometimes the diaphragm and other muscles of respiration are affected, and in that case, of course, a considerable amount of dyspnœa is produced.

In consequence of the length of his paper, Dr. Robinson omitted a portion of it, and occupied the remainder of his time with some remarks on treatment; first, however, giving a sketch of an interesting case of aneurism of the heart which recently occurred in his service at Charity Hospital, and in which the patient died from its rupture.

Pericarditis, endocarditis, and myocarditis, he went on to say, give rise to complications which are often of either a congestive or inflammatory character, and therefore local antiphlogistic treatment is of considerable service; but the principal reliance is to be placed on general remedies. Among those most used he mentioned quinine, the alkalies, atropia, and aconite. Quinine, however, at the present day was regarded as the *sine quâ non*, and he digressed for a few moments to discuss some of its properties and express his dissent from the views commonly held in regard to it in this country to day. The German authorities had been for some years lauding it as the great tonic and apyretic, and claiming that the larger the dose the better the effect,—which views seem to have been adopted by the mass of the profession in the United States. In France, however (and the English were more apt to adopt French than German opinions), quinine was acknowledged as a prompt apyretic when given in full doses, but was not regarded as a tonic, except in very small quantities, and even then it was much less efficient than the cinchona bark itself, and than iron, strychnia, and many other agents. Digitalis was the remedy which he would substitute for quinine in a large majority of instances; and he mentioned two cases at Charity Hospital which illustrated its beneficial effects. One was a case of capillary bronchitis, and one of double pneumonia, and both were under large doses of quinine when they came under his care. Though the temperature was not high, the dyspnœa and general distress were most urgent, and one of the patients seemed to be actually moribund. The quinine was withdrawn, and digitalis given in full doses instead, and the relief was almost instantaneous, while great improvement afterwards followed. Not only was digitalis a direct tonic to the heart, but it had the effect of gradually diminishing the pulse, respiration, and temperature, while its diuretic effect was also very valuable in carrying off the waste products of the system. In ordinary cases it was sufficient to give from five to ten minims of the tincture three or four times a day; but if the cardiac symptoms were urgent, he recommended drachm doses every four hours until relief was afforded. Dr. Robinson criticised the opinion, now apparently so prevalent, that in many febrile diseases a high temperature is the only source of anxiety, and that if that can only be brought down, all will be well. He claimed that high temperature of itself need cause no alarm unless it was accompanied by unfavorable symptoms, and that many cases of typhoid fever and scarlatina did perfectly well all through the attack, notwithstanding the fact that the temperature was very high. The sources and mechanism of fevers, he said, were not yet half understood; and he quoted a passage from Wunderlich to show how many elements have to be taken into consideration in appreciating this subject. He then mentioned a case of catarrhal phthisis in which the patient, a young woman, suffered from frequent fainting-spells when she took quinine. He increased the dose, under the idea that this would counteract the weakness which gave rise to them; but they only increased in frequency. When the quinine was withdrawn entirely, however, the fainting-spells ceased, and the patient was much improved, notwithstanding the fact that the temperature went up considerably. It was his custom frequently to administer Huxham's tincture, or small doses of strychnia, in connection with quinine. The following were some of the conclusions of Dr. Robinson at the close of his paper:

(1.) Pulmonary affections are frequently the immediate results of acute cardiac disease.

(2.) These complications are not so much

due to inflammatory as to mechanical obstruction.

(3.) To combat them successfully we must use some remedy (or remedies) which directly strengthens the heart's action, and gradually diminishes the pulse, respiration, and temperature.

(4.) Quinine does not fulfil these indications.

(5.) Digitalis does.

(6.) High temperature alone is not a cause for uneasiness in febrile affections.

Dr. Robinson having mentioned Professor Loomis as one of the principal advocates of large doses of quinine in this country, Dr. A. A. Smith remarked that in these days of quinine hobby he thought it only right that justice should be done those accused of riding this hobby, and that he feared that Dr. Robinson's paper would leave a wrong impression in regard to Dr. Loomis's opinions and practice. He said he had served under the latter at Bellevue Hospital, and that, while it was his custom to give quinine very freely in acute pulmonary diseases accompanied by high temperature, in the *secondary* affections of the lungs he relied almost exclusively on large doses of digitalis, together with alcoholic stimulus. He had frequently given, under his direction, tablespoonful doses of the infusion of digitalis every two hours.

Dr. Robinson explained that his criticism of Dr. Loomis had been based entirely on the published writings of that authority, and that he was glad to say that he entirely agreed with him as to the action of quinine on cell-proliferation in pneumonia and catarrhal phthisis.

Before the adjournment of the Academy, Dr. F. A. Burnall presented two specimens of urine from a patient suffering from *chyluria*, an affection which, though not uncommon in certain parts of Europe and South America, is very rare in this climate. He also read the history of the case, and made some remarks on the obscure character of the affection and the results of his examinations of the urine at different periods. The patient was a lady fifty-five years of age, a native of the Southern States, and first noticed the milky appearance of her urine about nineteen years ago, soon after giving birth to her fifth child. Since that period she has continued to pass chylous urine from time to time, and always feels considerably debilitated when this is the case. She has frequently experienced considerable pain in the right lumbar region, but never any in the left.

Of the multiplication of medical societies there seems to be no end. The first annual meeting of the "American Academy of Medicine" was held in this city on the 11th and 12th of September. The objects of this institution, which was organized September 6, 1876, in Philadelphia, are declared in its constitution to be "the advancement of medical science, the elevation of the profession, the relief of human suffering, and the prevention of disease;" while the Fellows of the Academy must be gentlemen who have received the degrees of Master of Arts and Doctor of Medicine, and who have had at least three years' experience in the practice of medicine in one or more of its recognized departments. The above objects are certainly very desirable; but how far this newly-organized body will be successful in carrying them out seems as yet somewhat problematical. The meeting of the American Academy of Medicine excited but a very small amount of interest among the profession in this city, and scarcely any of our prominent men took the trouble to attend it. Professor Traill Green, of Easton, Pennsylvania, the president of the Academy for the last year, made a very admirable address at the opening of the session, in the course of which he spoke eloquently of the scholastic attainments of Drs. Shippen and Morgan, of Philadelphia, the Bards, of New York, and the Warrens, of Boston, the founders of the first medical schools in their respective cities, and made a strong plea for a higher culture among the members of the medical profession at the present day. Afterwards the Hon. Lewis H. Steiner, M.D., of Frederick, Maryland, read a forcible paper on the advantages of the study of languages, both ancient and modern, to the student of medicine, in which he showed that the average practitioner of the present day in this country is not so well furnished with the elements of a liberal education as the one of fifty years ago. Certainly, if this society can succeed in raising the standard of preliminary education required for admission to our medical schools, it is deserving of the most earnest support of the profession; but, alas! there seems to be little prospect that a consummation so devoutly to be wished will be attained at any very early date. The names of the officers of the Academy elected for the ensuing year are as follows: President, Dr. Frank N. Hamilton, of New York; Vice-Presidents, Drs. Lewis H. Steiner, of Frederick, Maryland, Lee, of Philadelphia, Wickes, of Orange, New Jersey, and Henry G. Piffard, of New York; Secretary, Dr. R. L. Sibbet, of Carlisle, Pennsylvania; and Treasurer, Dr. Ed. H. M. Sell, of New York.

The first annual commencement of the Training School for Nurses at the Charity Hospital, Blackwell's Island, took place recently, and was a very pleasant affair. It was held in the large hall of the west wing of the hospital, which was tastefully decorated for the occasion with evergreens, flowers, and flags, and there was a large attendance of invited guests (among them Mayor Ely and Ex-Mayor Wickham), who came over to the island on the steamboat belonging to the Commissioners of Charities and Correction. The pupils of the school presented a very prepossessing appearance in their neat caps and

aprons, and certainly would have offered a very marked contrast to any body of nurses that could have been gathered from any of our hospitals ten years ago. Ex-Mayor Wickham presided, and gave a short history of the organization and subsequent career of the school. For several years, he said, the commissioners and himself had been awake to the abuses of untrained nurses in the hospital, and the desirability of founding such an institution as this; but it was not till August, 1875, that they were able to perfect and carry out the project. At that time twenty applications were received from young ladies, of whom nine were accepted; and it was with this number that operations had been commenced. Since then the school had gone on increasing, until it had now reached the number to which it is limited, forty pupils. The influence of these lady nurses had made a complete change in the *régime* of the hospital; severe punishments were no longer necessary, and there had been a marked decrease in the death-rate. A novel feature of the exercises was the reading of essays by several of the graduates, on such subjects as the following: "The Nursing of Children," "The Nursing of the Eye," and "The Duties of a Nurse." There was also read a very amusing composition on "Blackwell's Island," and a valedictory address by one of the young ladies selected by her companions. There were sixteen graduates, and three of them received prizes offered by Dr. Eastabrook, chief of staff, for passing the best examinations. There is only one objection that we can see to having such a class of nurses about a hospital, and that is that, some of the young women being very attractive, the members of the house-staff may be tempted to indulge in flirtations with them sometimes, and thus perhaps occasionally neglect their patients; but, even although this is the case, good may, no doubt, result therefrom to both the young men and the nurses. At least one match which was gotten up in this way has come to our knowledge; and it is certainly very nice for a youthful physician setting out in practice to have such a helpmate that, in case his magnificent anticipations of fortune and renown are not realized quite as soon as he expected, she may be able to turn to account her knowledge and experience in the care of the sick in such a manner as to assist in "keeping the pot boiling" until the practice has sufficiently increased to enable him to dispense with her professional services.

Some eighteen cases of yellow fever, the most of them coming from Havana, have lately been reported from Quarantine, and no less than half of them have proved fatal. There has also been one death from the disease in the city. The patient was a gentleman who came by rail from Florida, and was apparently in excellent health for several days after his arrival here. When he became ill he was taken to the New York Hospital, where he died in a very short time. More recently another case of the fever, which had been admitted to the Roosevelt Hospital, was ordered by the Board of Health to be transferred to Quarantine, the authorities holding that it was better that the patient should undergo the risk of removal than that his being allowed to remain should occasion needless alarm in the city. It seems, however, that he was in a very low condition at the time of his removal, and only survived for a few hours after reaching the hospital on Dix Island to which he was taken; and, as yellow fever is not regarded as a contagious disease, the friends of the deceased are naturally inclined to criticise the action of the Health Department in the matter very severely. They claim that he would have had a chance at least to recover if he had been allowed to remain at the Roosevelt, and that this was entirely destroyed by his removal, so that the authorities are in a measure responsible for his death.

In the large fire which occurred in this city early in September, when Hale's piano factory and other buildings were destroyed, a member of the Fire Department had his leg broken and was pretty badly bruised by a portion of a wall falling upon him; but when, after considerable difficulty, he was taken from underneath the débris, he seemed to regard it as quite a trifling matter, exclaiming, "Oh, this is nothing!" On his way to Bellevue Hospital he explained to the ambulance-surgeon that at the burning of Barnum's Museum, on Broadway, near Prince Street, he had had both his arms and both his legs broken, so that he regarded himself as having got off with very little damage on this occasion.

On the 19th of September, Dr. Alexander B. Mott successfully *ligated* the *common iliac artery* in a patient, at Bellevue, suffering from femoral aneurism noted very high up.

Dr. Leroy M. Yale, Lecturer Adjunct upon Orthopædic Surgery at Bellevue Hospital Medical College, has been appointed attending surgeon to Bellevue Hospital, in the place of Dr. A. B. Crosby, deceased.

During September the usual preliminary autumnal courses have been given at all the medical schools, and in the first week of October the regular winter sessions will commence. The large number of New York medical men who have been abroad during the summer have nearly all returned by this time; but Dr. Sims, it is reported, will remain permanently in Paris. His oldest son, Dr. Harry L. Sims, has recently removed to San Francisco, whither he was accompanied in the early part of the summer by his father, and where he expects to practise his profession for the future.

The residuary legatees of the estate of the late John C. Green, of this city, have given the

sum of $50,000 to the Presbyterian Hospital here, the interest of which only is to be used for the benevolent purposes of the institution. They have also made a similar donation to the S. R. Smith Infirmary, at Edgewater, Staten Island, a charity for the medical and surgical relief of the poor of the island.

P. Brynberg Porter.

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

Thursday Evening, September 10, 1877.

The President, Dr. H. Lenox Hodge, in the chair.

Cystic suppurating kidneys. By Dr. C. B. Nancrede; notes by Dr. Fairfax Irwin.

THIS man, aged 75, admitted August 6, 1877, has experienced a difficulty in passing his water for the last nine months. He says it comes away in very small quantities at a time, and with much straining. Says he has not had a stool for nine days. There seems great pain on pressure over the abdominal region, which is swollen and tumid. Face is flushed; pulse full and rigid, 65 per minute; the artery has an atheromatous feel; heart-sounds are weak; first sound more valvular than natural; second sound accentuated. Cannot pass a metallic catheter, but succeeded in passing a No. 5 flexible catheter; drew off half a pint of urine. There is evidently a great enlargement of the prostate gland. Ordered ol. ricini, f℥ss, and turpentine stupe to the abdomen.

August 7.—Better to-day; bowels slightly opened; catheter used. Ordered potassii bitartratis and infusion of juniper. 6.30 P.M. Ordered enema of turpentine and ol. ricini; caused much pain; ordered sup. opii gr. ij.

August 8.—Has had no passage; ordered Epsom salts and six ounces of punch; drew off about one quart of urine with catheter; ordered pill of colocynth gr. ij, ext. belladonnæ gr. ½, pil. hydrargyri gr. j.

August 9.—Has had three stools; discontinued pills; ordered turpentine stupe to abdomen.

August 10.—Worse to-day; suppression of urine; ordered cat. lini to abdomen; passed a stomach-tube up the rectum to sigmoid flexure; little result.

August 11.—Has not passed more than a drachm of urine; ordered inf. digitalis ℥ss t. d., and cat. lini to abdomen; passages very liquid; steadily grew worse, and died at half-past three A.M.

August 12.—*Post-mortem examination.*—Rigor mortis well marked. Hyperstasis of posterior parts of the body. Heart enlarged; tricuspid stenosis; left ventricle, aorta, pulmonary artery, and vena cava ascendens contained large, firm ante-mortem clots. Both kidneys contained abscesses; the left a cyst also. Peritoneum inflamed. A few bands of old lymph were found constricting the ileum and rectum, thus accounting for the partial intestinal obstruction.

Dr. Harrison Allen said the mention of suppression of urine and the difficulty of telling it from retention interested him, and reminded him of a case which came under his observation,—that of a woman who had been drinking and had passed no urine for three days. He introduced a catheter, and was surprised to obtain but a very small quantity of perfectly fresh appearing urine. Her abdomen was large, and he thought possibly he had not entered the bladder perfectly, and went for his case of catheters. He found, however, that he was right. Dr. Allen had asked himself the question why this should be. It occurred to him that there might have been an overloaded cæcum, which, pressing on the ureter, retained the urine in it for a time. So in Dr. Nancrede's case, could not the ureter have been compressed by the product of subperitoneal inflammation?

Dr. Nancrede said it occurred too soon after free micturition to make this a probable cause. He referred to a case in which the urine contained blood and a small quantity of albumen, followed by a peculiar train of symptoms, eclampsia, cough, fetid breath (whence gangrene of the lungs was suspected), and afterwards great abdominal pain. After death one kidney was found converted into a thin-walled sac, containing a large amount of thin fluid, with complete obstruction of the ureter. He thought it not improbable that the man had had old kidney disease, and pyæmia had supervened upon the passage of instruments.

Dr. Allen said that all are familiar with the fact that in dropsy diuretics will not act until the bowels are relieved by purgatives, because of the previous pressure on the renal vein. He thought his supposition in this case not impossible.

Dr. H. Lenox Hodge said that it would be very difficult for any growth or enlargement to press so firmly upon the ureters as to prevent the urine from entering the bladder. The attachments of the ureters are so loose and the mobility so great that they readily recede from the pressure of any enlargement. Their coats are so thick and strong as to resist great pressure. It would be almost impossible for any enlargement to compress a ureter on all sides at once, or to press it against the bony walls of the abdomen or pelvis. Urine would reach the bladder unless the pressure occluded both ureters at the same time.

Dr. Allen said this, in his judgment, did not apply to the ureter low down in the pelvis, where it lies in the female, at the side of the true pelvis, previous to the canal inclining downward and inward towards the bladder.

As the ureter passes through the uterine plexus of veins near the cervix uteri, it is liable to be compressed by morbid products situated therein, and can even be lacerated in over-distention of the os. So that, in its pelvic relations at least, a comparatively slight cause might squeeze the ureter against the side *of*, or compress it at some other point *within*, the pelvis.

Dr. NANCREDE said there were old bands of lymph constricting the intestine, but the distention of the abdomen was almost entirely due to gas.

Dr. M. O'HARA thought, as to the opinion expressed by Dr. Allen, that the pressure of the column of fluid on the ureter, backed by the force of the blood, was very great, greater than any pressure from the abdominal effusion in ascites. We can form some idea of the amount of this *vis a tergo* from the enlargement of the bore of the ureter on the passage downwards of a large calculus, and we would feel assured that no mere weight of a passive fluid pent up in the abdomen would be able to overcome such a force.

Small calculus. By Dr. NANCREDE; notes by Dr. ROBT. MEADE SMITH.

R. D., æt. 4, admitted to children's surgical ward, Episcopal Hospital, September 5, 1877, with vesical calculus. Robust, healthy-looking boy.

Examination of urine.—Pale amber color; slight yellow flocculent deposit; reaction faintly acid; sp. gr. 1015; a trace of albumen. *Microscopically.*—Pus corpuscles, few blood-disks, squamous and cylindrical epithelium; no casts or crystals; granular débris. After having had bowels well opened with castor oil and enema, Dr. Nancrede extracted, by lateral lithotomy, an oxalate of lime calculus weighing sixteen grains. No accident or hemorrhage occurred in the course of the operation. The patient rapidly reacted from the ether which had been administered. Placed on milk diet. Some little oozing which occurred in the afternoon yielded to elevation of pelvis and application of cold. Slept all night.

Epithelioma of glans penis. By Dr. COMEGYS PAUL.

On the 15th of last May I first saw the patient who furnished this specimen. The glans penis was then a mass of ulceration, with exuberant granulations and many minute sinuses, from which a very slight pressure would cause to appear numerous vermicular bodies of a caseous consistence.

Nine months before, he first noticed a small ulcer situated in the depression behind the corona glandis, and involving the skin only. It gradually increased, although skilfully treated by his medical attendant. When he came under my professional care, I made efforts to cut down the granulations by caustics and stimulating ointments, and laid open the sinuses above mentioned, besides giving attention to his general health. He is a married German, aged 52 years, and has never had syphilis. It was at first suspected that this condition had a syphilitic origin, and specific treatment was at one time adopted, but without any benefit, as was also the effect of all other treatment. Loss of sleep at night from pain, and the long-continued discomfort, at length began to undermine his strength and led me to recommend amputation. This he readily agreed to, and the operation was performed two weeks ago with entire relief. The method chosen was that of Ricord, in which, after the division of the parts by a circular sweep of the knife, the urethra should be split at several points and united to the skin with interrupted sutures. The result in this case is a stump about two inches long, the end presenting all the characteristics of a healthy wound, and partially covered with a foreskin.

REVIEWS AND BOOK NOTICES.

HOW TO USE THE OPHTHALMOSCOPE: BEING ELEMENTARY INSTRUCTIONS IN OPHTHALMOSCOPY. By EDGAR A. BROWNE, Surgeon to the Liverpool Eye and Ear Infirmary, etc., etc. Philadelphia, 1877.

The practical use of the ophthalmoscope is generally considered a terrible bugbear by not only students of medicine, but by many of the general practitioners; and in this little book Mr. Browne has done a good work in laying before them in a clear, concise, and complete form all the necessary practical points for those who desire to learn the use of the instrument and the examination of the different parts of the eye, as well as a little insight into the distinguishment of defects of refraction. The whole subject is treated in an elementary manner suitable for the beginner.

The arrangement of his work is very good, beginning in Section I. with the explanation of optical principles, laws of light, reflection, refraction, etc., and the eye as an optical instrument. In Section II. a sketch of the ophthalmoscope and the manner of its use is given. In Section III. there are descriptions of the appearances of the media, optic disk, vessels, retina, and choroid in a state of health; and in Section IV. he presents the diseases of the different parts, with practical use of the instrument in determining what part is affected, as well as its character and situation. In this section he touches lightly upon the defects of refraction, as it would be impossible to enter into such a deep and profound region in so small a work. For those who desire to go farther in the study he presents a list of standard works upon the subject.

What appears strange, however, is his recommendation of Liebreich's ophthalmoscope for a learner. This instrument was good in its day, but has been greatly improved on.

It is awkward to be slipping the lenses in the clip behind the reflector, while in the more modern instruments, such as Loring's and Knapp's, there is a series of convex and concave lenses in a rotary disk behind the reflector that can be turned while the instrument is held before the eye. And as they cost but little more, it would be advisable to get an instrument that will always be serviceable.

The book is well illustrated, and altogether gotten up in fine taste and order. It is the only work published on this special subject in English since that of Hulke, in 1861, and B. Carter's translation of Zander, in 1874; and we commend it to all students and practitioners who are desirous of getting an insight into the principles, use, and workings of this instrument as well as the knowledge of the fundus of the eye, etc. K.

FORENSIC MEDICINE AND TOXICOLOGY. By W. BATHURST WOODMAN, M.D., F.R.C.P., and CHAS. MEYMOTT TIDY, M.D., F.C.S. Philadelphia, Lindsay & Blakiston, 1878.

This work is comprised in one large octavo volume of nearly eleven hundred pages, and therefore compares in size with the two-volume treatise of Taylor. Without containing much, if any, original matter, it is well written, and very fairly represents the science of the day. It has seemed to us that that portion of the book which treats of other than toxicological matters is fuller and more absolutely satisfactory than is the section on poisoning. Whatever meagreness here may exist is not so much in the chemical aspects of the subject as in the history of symptoms, their character and import, and the best methods of treatment. We are pleased at the conservative advice given in regard to blood-stains; namely, that it is best on the witness-stand, unless in very exceptional cases, to confess inability to answer the question, Was the blood human? The chapter on gunshot wounds is very full and modern, and even affords opportunity for a flight in the higher mathematics. The book is well illustrated by means of both wood-cuts and chromo-lithographs.

So many excellent treatises on medical jurisprudence and toxicology are already in the market that no great necessity for the present volume seems to have existed. But, having undertaken their task, Drs. Woodman and Tidy have performed it well, and have added to the list already clamoring for patronage a work which, though not strikingly novel, is a well-gathered-together, clearly-written, useful treatise.

THE PRACTITIONER'S REFERENCE BOOK. ADAPTED TO THE USE OF THE PHYSICIAN, THE PHARMACIST, AND THE STUDENT. By RICHARD J. DUNGLISON, M.D. Philadelphia, Lindsay & Blakiston.

This is a large octavo of about three hundred and sixty pages, clearly printed on excellent paper, and altogether forming a goodly volume. Its scope, so far as our memory serves, is a novel one; though whether the expressed hope of the author, that the book will "become an indispensable companion as a handy-book for every-day consultation," will be realized, is at present an open question. The introduction is the Hippocratic oath; after it comes a chapter entitled "General Information," taken up with weights and measures, thermometric scales, solubilities of various drugs, and abbreviations in common use. "Therapeutics and Practical Hints" occupies the next two hundred pages of the book, constituting its *pièce de résistance*. Doses of all kinds and varieties, incompatibilities, management of infants, obstetric hints and memoranda, urinary examinations, poisons, disinfection, artificial respiration, the modern treatment of disease, a table of diseases with remedies, etc., make up the olla-podrida of this remarkable literary banquet. The next course is "Dietetic Rules and Precepts," and finally for dessert we have the "Method of Making Post-Mortem Examinations." The well-known carefulness of Dr. Dunglison, and the wide extent of his knowledge of medical literature, fit him for preparing a work of character like the present, and we commend it to any who feels the need of such a volume.

PRACTICAL HINTS ON THE SELECTION AND USE OF THE MICROSCOPE. Second Edition. By JOHN PHIN. New York, The Industrial Publication Company.

The sale of a large edition of this book in two years justifies the favorable opinion which we expressed in the review of the first edition.

GLEANINGS FROM EXCHANGES.

QUININE EXANTHEM (*The Medical Record*, September 22, 1877).—Prof. Köbner, of Breslau, reports the case of a large, powerfully-built woman, 28 years of age, who was attacked with a syndrome closely resembling that of scarlet fever, whenever she took even a small dose of quinine. The symptoms consisted in a chill, which was sometimes repeated, a feeling of præcordial anxiety, nausea, vomiting, intense headache, high fever, and angina. A few hours after the chill an erythematous eruption made its appearance on the face, and spread rapidly over the entire body. It was attended by intense burning and itching, by slight œdema of the face, and injection of the conjunctiva. The color disappeared for a moment on pressure. The eruption on one occasion completely covered the entire body; on another, it was confluent on the upper part of the body, but discrete on the legs. On this occasion the eruption on the legs was slightly papular, and the lower border of the confluent part was not sharp, but gradually faded into the healthy skin. After a variable length of

time, according to the amount of quinine taken, the symptoms abated and desquamation began. The angina affected only the posterior wall of the pharynx, the soft palate and pillars being normal. Three times in the course of five months the patient was seized with these attacks. The first time, the exanthem broke out after three and a half grains of quinine had been taken. As a diagnosis of scarlet fever was made, the quinine was continued for eight days, and the eruption persisted for the same length of time. Desquamation then began, and continued for six weeks, and on the soles of the feet, in fact, for nine weeks. The fever was high and persistent, and the prostration was very great.

Three months later the exanthem reappeared, after a dose of two and a quarter grains of quinine. The stage of eruption lasted four days, and the desquamation three weeks. The third time, the exanthem made its appearance after a dose of only one and a half grains of quinine. The stage of eruption lasted only two and a half days, and the desquamation fourteen days. The affection this time ran a milder and shorter course than on the two previous occasions.

Dr. Von Heusinger, of Marburg, states that he has met with two cases in which symptoms entirely analogous to those described above were produced whenever even very small doses of quinine were administered. In these cases, however, the eruption was confined to the face. Both patients were women. One of them was at one time able to take quinine without inconvenience.

An Epidemic of Lead-Poisoning (*The Medical Record*, September 22, 1877).—A very large number of cases of lead-poisoning have recently occurred in the 8th and 17th wards of Paris. Dr. Ducamp has had sixty-five of these cases under observation, and he made them the subject of a paper read before the Société de Médecine Publique on July 25. The patients belonged to all classes of the population; in some families all the members, both old and young, were affected. After careful investigation, Dr. Ducamp found that all his patients were served from the same bakery, and, as he could positively exclude all other methods by which the poison could be introduced into the system, he came to the conclusion that the bread was the agens morbi. Chemical examination showed that it contained lead; it was evident, however, from the character of the baker, and from the fact that he and all his family were among the most severely affected victims, that the lead was not placed in the bread with criminal motives, while, on the other hand, the fact that the water and flour used were the same as were used by the neighboring bakers, whose bread was not poisoned, showed that these substances were not toxic. Dr. Ducamp finally ascertained that the baker had been making use of old wood taken from demolished buildings, to heat his ovens, and here he struck the root of the trouble. This wood had been repeatedly painted with white lead, and when it was consumed by the fire an oxide of lead was formed, which was deposited in a pulverized form on the floor of the oven. When the embers were withdrawn, and the bread put into the oven, the oxide of lead probably adhered to the bottom of the latter, and was removed with it. The correctness of this theory was confirmed by two striking facts: the persons whose duty it was to brush the bread, and who must have detached a portion of the lead and inhaled it in the form of dust, were the first to be affected, and had the most severe attacks. Again, in one family there were two women, of whom one ate only the soft part of the bread, while the other ate the crusts. The former escaped entirely, but the latter was attacked so severely that her life was in danger.

Treatment of Blennorrhagic Epididymitis with Iodoform Ointment (*The Clinic*, September 22, 1877).—Dr. Alvares, of Palma (Majorca), has treated four cases of epididymitis with iodoform ointment, and from his experience draws the following conclusions:

1. Iodoform calms the pain of blennorrhagic orchitis better than any other application: this result is obtained at the end of one or two hours.

2. Iodoform exerts a very manifest resolvent action, and has the advantage over the usually employed mercurial ointment of causing no trouble when absorbed.

3. The iodoform treatment shortens very appreciably the duration of the orchitis, and prevents any consecutive induration of the organ.

4. It is necessary to employ an ointment containing, according to the intensity of the inflammation, from one to two grammes of iodoform to thirty grammes of lard.

Lacerations of the Cervix Uteri as a Cause of Uterine Disease (*The Boston Medical and Surgical Journal*, September 20, 1877).—Dr. W. H. Baker reports twenty cases where laceration of the cervix uteri during labor has been a cause of severe uterine disease. He found the accident to occur most often in those labors which were rapid, with severe pains; also frequently in cases which had required the application of the forceps. In fourteen of these cases the laceration was on the left side of the cervix. Eleven of the cases were operated upon by Dr. Emmet's plan with the most satisfactory results. Dr. Baker gives the following résumé of the general symptoms of these troubles:

The first thing which attracts our attention in the list of symptoms is the tardy recovery of the patient, a "bad getting up," as she expresses it, and when more than the usual time has elapsed, and she thinks she should be able to be about, she feels somewhat discouraged on account of her inability to stand;

or it may be that with the attempt to walk more or less hemorrhage is noticed. As time goes on, intercourse may be complained of as being painful, or perhaps followed by a slight show; there is ever present backache, a sense of weight in the pelvis, pains extending down the thighs, a sensation of heat or burning in the hypogastrium, irregularities in menstruation, and throughout the whole there persists a more or less abundant leucorrhœal discharge. As the nervous system is continually taxed by the foregoing symptoms, it finally claims its full share in the trials to which the patient is subjected, and she is probably by this time a confirmed invalid, and may indeed think herself fortunate if she is not confined to her bed, a truly deplorable wreck.

The physical signs change very much, of course, as the case progresses. At an early stage we are struck by the size and softness of the cervix, and by the aid of the speculum we see at once the everted membrane of the canal, the epithelial layer of which is often abraded; later we have the large flattened, appropriately termed mushroom cervix, with its firmer tissue and shot-like feel; and still later we find the cervix hypertrophied, the tissue firm and indurated, and if it has been treated with caustics the surface covered over with cicatricial tissue and the substance as hard as a piece of granite. Or, the case having been left to itself, the epithelium becomes abraded, and the constant friction to which the part is exposed keeps it constantly irritated, so that the appearance might readily be mistaken for that of malignant disease. To all these appearances in this latter stage we might have added the various malpositions which have been occasioned by the change which has taken place in the cervix.

Exfoliation of the Cuticle after the Death of the Fœtus (*The Boston Medical and Surgical Journal*, September 20, 1877).—At a recent meeting of the Boston Obstetrical Society, Dr. Abbot, in answer to the question how long an interval of time is necessary after the death of the fœtus to produce exfoliation of the cuticle, said that he was recently called to a patient about to be confined, who was very large and uncomfortable from excessive distention. On examination in the afternoon he heard the sounds of the fœtal heart distinctly; and the patient stated that she felt the motion of the child subsequent to the visit. On the second day after, a large dead child, weighing about ten pounds, was born. In the process of delivery there was considerable delay in the passage of the shoulders, and when they at length came a sheet of cuticle was peeled from the entire abdomen. During three or four weeks before labor, dating from an attack of cholera morbus, the motions of the child had been growing gradually feeble, and for the last week had been scarcely perceptible. The sagittal suture was unusually wide, as if from distention by an excessive amount of serum in the brain, and the abdomen was somewhat enlarged. The child was plump, and there was no appearance of maceration of the cuticle. The labor was a hard one, there being scarcely any liquor amnii. From the positive data of this case, the child could not have been dead more than thirty-six hours previous to delivery, and possibly not more than twenty-four.

Dislocation of the Hip (*The Louisville Medical News*, September 8, 1877).—Dr. W. O. Roberts reports the case of a girl, aged eight, who tripped and fell while running. She afterwards complained of pain in the left hip, and was confined to her bed for a day, but her parents did not notice that anything serious was the matter. She got up, walked about with something of a limp, which was still attributed to sprain or contusion. It was two weeks after her fall that Dr. Roberts was sent for to see her. He found then plain evidences of a dislocation. The right limb was fully two inches longer than its fellow. The limbs could be easily brought together while she was in a recumbent posture, and there was then no tendency of the injured one to project forward, although when she walked, which she did easily, there was projection of the limb, and some flexion at the knee. Reduction was made under chloroform, by Reid's method, quite easily after four or five revolutions. When the thigh was flexed over the abdomen, it went straight upward, inclining neither to the right nor the left, and the circumduction could be made with equal facility outward or inward. It was during an outward turn that the head of the bone was restored. The diagnosis was a dislocation forward and *below* the thyroid foramen on to the tuberosity. While locomotion is often preserved to a considerable extent in the thyroid dislocations, especially in children, the facility with which it could be performed in this case, where the head of the femur was thrown so far from its seat, was remarkable.

Morphia (*The Boston Medical and Surgigal Journal*, September 20, 1877).—M. Calvet presents (*Thèse de Paris*, 1877) (1) a physiological research of the action of morphine upon the various functions of the organism; (2) a clinical study of morphine as a therapeutical agent, especially in the relations of acute to chronic morphinism. In the first, he observes that both intravenous as well as subcutaneous injection of the hydrochlorate of morphine accelerates respiratory movements, succeeded by a period of retardation, and produces sometimes a momentary arrest or respiratory syncope. The same relative effects occur with the cardiac movements: at first accelerated followed by retarded pulsations; sometimes even cardiac syncope. During this time animal heat exhibits analogous phenomena, namely, the elevated is followed by lowered temperature. In fact, the absorption of morphine, whether by intravenous or sub-

cutaneous injection, produces a very marked influence upon the reflex actions. In certain cases the period of exaltation does not occur, but immediately after the administration of the drug the temperature becomes lowered and the respiratory and cardiac movements are slower. Though he has not finally completed his researches, M. Calvet advances the opinion "that the above phenomena are dependent upon the integrity of the connection between the pneumogastric nerves and the encephalon, for if these two nerves are severed the above-named effects do not occur, but only the ordinary sequelæ observed after this section." In the second portion of this thesis M. Calvet offers the following interesting observations on chronic morphinism. Nutrition is deranged, the animals becoming emaciated; for instance, an animal who had received during a month a total amount of 3.52 grammes (twenty-five grains) of hydrochlorate of morphia lost almost half his weight, became torpid, had dilated pupils, walked with a jumping step, as if he had exalted sensation in the plantar surface. In this and other animals the secretions of saliva and urine were very much diminished; they died more often from marasmus or defective nutrition, but sometimes from convulsions as well marked as those which are observed in poisoning by strychnine. The anatomical post-mortem lesions observed in these cases were in the arterial encephalo-medullary region, and apoplexy in the vessels of the heart and stomach. Morphine was found in all the organs of the body, but not in the saliva or urine.

Tracheotomy in Tuberculosis of the Larynx (*The Clinic*, September 22, 1877).—We are accustomed to consider tracheotomy in laryngeal tuberculosis simply as a possible means of prolonging life for a short period. Dr. Seckowski, however, is of a different opinion. He has operated twice for tuberculosis of the larynx, and one of the cases on whom the operation was performed seven years ago is still alive, whilst the other lived for three years. Post-mortem examination of the latter showed well-advanced phthisis. The one still living was attacked with severe dyspnœa immediately after her return from a long journey. The writer resorted immediately to tracheotomy, when, after the introduction of the canula, his patient fell into a natural sleep which continued for forty-eight hours. Under general treatment her strength was regained and her cough left her, but she continued to wear the canula most of the time for two years,—that is, until laryngoscopic examination showed that the former morbid condition had left behind only a thickening of the vocal cords. Two years later there was still marked dulness to percussion over the apex of the right lung. Since that time she has never been examined; but the writer often sees her in an apparently well-nourished condition.

He expresses the opinion that the opening in the trachea was not only of temporary benefit, but that it prevented the extension of tuberculosis. He considers it necessary that the opening of the glottis should be sufficiently large to allow the easy expectoration of purulent secretion from the lungs, as well as the entrance of plenty of air. He therefore believes tracheotomy to be indicated in all contractions of the larynx, particularly in tubercular patients, for it saves the larynx as well as the lungs. It would not seem to be indicated in those cases in which the lungs are more affected than is the larynx.

Tubercular Ulcer of the Tongue (*The Lancet*, July 21, 1877).—M. Nedopil, in the *Archiv für Klinische Chirurgie*, Band xx., remarks that the diagnosis of secondary tubercular ulcer of the tongue is generally not difficult, in the presence of other indications of tuberculosis. On the other hand, primary tubercular ulcer can often be scarcely distinguished from cancer unless a microscopic examination be made; while the failure of anti-syphilitic remedies denotes that the affection is not a syphilitic ulcer, which often has a similar appearance. The tubercular ulcer of the tongue runs a course resembling that of cancer. A small hard nodule on the edge or upper surface of the tongue, which is often overlooked, at last falls off and leaves a dirty ulcer with an indurated base, which generally spreads more slowly than a cancerous ulcer. A cure can be produced only by early extirpation, which perhaps may arrest the development of general tuberculosis. The author has observed four cases in Billroth's clinic: two of the individuals were thirty-two years of age, the others sixty-eight and seventy. In three cases the ulcer was extirpated, and healing took place in a few days. In the excised pieces, the tissue around the ulcer was studded with miliary tubercles, mostly towards the free surface. The morbid process appears to commence with a general transformation of the muscular tissue into a homogeneous slightly granular plasma, containing proliferating muscle-nuclei. Later, the primary deposits become confluent, and giant-cells are formed from the obstructed portions of the blood-vessels; in some of these Nedopil found cavities filled with brown pigment. The growth of the tubercle appears to take place partly through proliferation of nuclei (without cell-formation) in the interior, partly through metamorphosis of the neighboring tissue.

In a breach-of-promise suit at Leicester, England, it was proven that the defendant, a clergyman, had taken five pills a day during a period of ill health which extended over thirty years. According to this, he must have swallowed some fifty-five thousand pills,—a fact which certainly entitles him to rank as one of the chief pillers of the church.

MISCELLANY.

JAPANESE PATIENTS.—Dr. Vidal, physician at Jokoska, Japan, writes that, according to the formulæ of speech, a treasure would not suffice to pay the advice of so great a sage as the educated physician, wherefore the Japanese content themselves with not paying him for his services, but only allotting a few pence for medicine and expenses of the visit,—a sum so insignificant that more often the European physician would feel insulted by its being offered, and therefore contents himself with the profuse compliments of his clients. On the whole, he does not consider a Japanese *clientèle* profitable; and, if cultivated at all, it could only be accepted as a supplement to a practice among the resident Europeans.—*British Medical Journal.*

PROFESSOR GROSS.—According to his own statement, in a letter to the *Louisville Medical News*, Prof. Gross, of this city, is now in his seventy-third year. We sincerely trust that in his eighty-third year the venerable master of American surgeons may still be able to write, "I never possessed greater aptitude for mental labor than I do at present. Naturally of a sound constitution and regular and systematic habits, with a well-regulated temper, I never miss a lecture or fail to meet a professional engagement."

THERMO-CAUTERY.—According to the *British Medical Journal*, the performance of tracheotomy by the thermo-cautery is a very customary feat now. The height of this retrogressive fashion has possibly been attained by M. Th. Auger, who has performed perineal section for a prostatic calculus by the thermo-cautery. This almost rivals the performances of the late M. Chassaignac with the *écraseur*.

AT the Pennsylvania Hospital, during the last year, ending May 7, 1877, there were treated, in-door department, 1773 patients; out-door department, 3563 patients. The legacies and donations to the permanent fund amounted to over $7000.

FASHIONABLE ENTERTAINMENTS FOR THE WEEK.—"Going to the Throat and Ear Ball, Lady Mary?" "No; we are engaged to the Incurable Idiots." "Then perhaps I may meet you at the Epileptic Dance on Saturday?" "Oh, yes, we are sure to be there. The Epileptic managers are so delightful."—*London Punch.*

UNDER the head of "Honors to an American," the *St. Louis Clinical Record* makes the following very severe statements, which if true ought to be generally known, and if not true ought to subject the editor of the *Record* to damages for libel:

"Several of our contemporaries are giving great prominence to Dr. Sayre's very flattering reception in England. It seems that Dr. Sayre went to England to advertise his (*sic*) method of treating spinal curvature. He intends to publish a book describing his (?) processes, and expects a large sale under an English copyright.

"This would be all very well—in fact, just as it should be—if Dr. Sayre had ever invented anything, which he never did, so far as we are informed.

"'Dr. Sayre's hip-joint splint' was invented by Dr. Davis.

"'Dr. Sayre's plaster-of-Paris jacket' was invented and first applied by Dr. Bryan, of Lexington, Kentucky.

"'Dr. Sayre's method of self-suspension in rotary-lateral spinal curvature' was invented by Dr. Benj. Lee, of Philadelphia.

"'Dr. Sayre's lectures on orthopædic surgery' were by Dr. Louis Bauer, formerly of Brooklyn, New York, now of St. Louis.

"As a plagiarist and 'father of other men's ideas,' Dr. Sayre is without a rival. We are glad to see that our English cousins delight to honor such representative Americans (Heaven save the mark!) as P. T. Barnum and L. A. Sayre. *Vive le humbug!*"

DR. MATTHEWS DUNCAN, having accepted the invitation to assume the duties of obstetric physician to St. Bartholomew's Hospital, will settle in London.

SPINA BIFIDA.—A case of successful treatment with the elastic ligature is reported in the *Medical Times and Gazette*, August, 1877, p. 213.

NOTES AND QUERIES.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

DEAR SIR,—In your issue of September 15, 1877, is contained a communication on "The Successful Treatment of Three Cases of Pityriasis Rubra." Perusal of this paper shows beyond question that the cases therein referred to cannot possibly be regarded as examples of pityriasis rubra as the name is understood and employed by writers on diseases of the skin of the present day. What affection precisely is meant, it is difficult to determine from the notes, for they are too brief to enable one to arrive at any conclusion; but that the cases were not true pityriasis rubra—an extremely rare disease, single instances of which are only very seldom encountered, even in largest clinics for diseases of the skin in Europe—appears evident from the description of the symptoms, history, and course of the disease, which are quite at variance with what is known concerning this affection.

Very truly yours,

L. A. DUHRING.

PITYRIASIS RUBRA (?).

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

SIR,—In a recent number of the *Medical Times* (September 15) there appeared an article including "Notes of Three Cases of Pityriasis Rubra." I trust I shall not appear hypercritical if I express frankly very serious doubts as to the correctness of the designation which has been applied to these cases. Not having seen them, it would perhaps be rash to express a decided opinion as to their true nature. The description, however, of the affection, as given in the article referred to, might easily apply to psoriasis. Pityriasis rubra is one of the rarest among skin diseases. So far as I am aware, but a single case has been reported in this country.

Very truly yours,

ARTHUR VAN HARLINGEN.

A CORRESPONDENT requests light as to the best treatment of urticaria or hives; also a formula for application to chafed infantile skin. Will some of our subscribers please give it through these columns?

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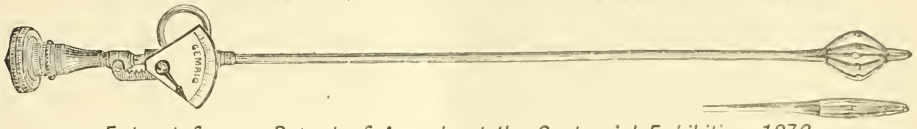

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